Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NISAL CORP
PO BOX 24809
HOUSTON TX 77029

Respondent Name

LIBERTY INSURANCE CORP

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-11-0076-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "violation of rule 133.240."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "At the time these bills were received this provider was not listed as a member of the HCN but the records do indicate that the facility is now contracted. However, these charges were billed with procedure code 95833 which is for Body Muscle Testing. We have attached a copy from the ODG for diagnosis 722.10 showing that this code is not recommended. Therefore, the charges remain denied as not within the ODG."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 11, 2009	CPT code 95833	$50.00	$50.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputes service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 21, 2010

   - X397, 38-Provider is not within the Liberty Health Care network (HCN) for this customer. TX Insurance Code 1305.804 (B) and Labor Code 401.011.

   Explanation of benefits dated March 9, 2010

   - U301, 18-This item was reviewed on a previously submitted bill, or on this bill, with notification of decision issued to payor or provider (Duplicate billed).

Issues

1. Does a contractual agreement issue exist in this dispute?
2. Did the respondent file response in accordance with 28 Texas Administrative Code §133.307 (d)(2)(B)?
3. Is the requestor entitled to reimbursement for CPT code 95833?

Findings

1. The respondent denied reimbursement for the disputed services based reason code "X397, 38-Provider is not within the Liberty Health Care network (HCN) for this customer. TX Insurance Code 1305.804 (B) and Labor Code 401.011".

   The respondent states in the position summary that "At the time these bills were received this provider was not listed as a member of the HCN but the records do indicate that the facility is now contracted." Therefore, a contractual agreement issue does not exist and the disputed service will be reviewed per applicable Division rules and guidelines.

2. The respondent states in the position summary that "these charges were billed with procedure code 95833 which is for Body Muscle Testing. We have attached a copy from the ODG for diagnosis 722.10 showing that this code is not recommended. Therefore, the charges remain denied as not within the ODG."

   28 Texas Administrative Code §133.307 (d)(2)(B) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MDR will be dismissed in accordance with subsection (e)(3)(G) or (H) of this section."

   The Division finds that the respondent did not raise the issue regarding compliance with the ODG; therefore, this is a new issue that is being presented and not in accordance with 28 Texas Administrative Code §133.307 (d)(2)(B).

3. CPT code 95833 is defined as "Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands".

   28 Texas Administrative Code §134.203(a)(5), states "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code (c)(1) states "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32."

   28 Texas Administrative Code (c)(2) states "The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with

the exception of surgery) Division conversion factor in 2007."

The 2009 Division conversion factor is $53.68.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77004, which is located in Harris County.

The MAR for CPT code 95833 in Harris County is $52.48 (WC Conv 53.68/Medicare Conversion 36.0666 X $35.26 participating amount). The respondent paid $0.00. The difference between the MAR and amount paid is $52.48. The requestor is seeking reimbursement of $50.00; this amount is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $50.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $50.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		5/31/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.